Severe Illness (ICU Admission) or Death in Pregnant or Postpartum Woman
Case Report
Centers for Disease Control and Prevention

Instructions: States are encouraged to use this form to report all pregnant and up to six weeks postpartum women with lab-confirmed influenza and admitted to an intensive care unit (ICU) or who died to the Maternal Health Team, CDC. Forms can be scanned and emailed, faxed, or called into the reporting line.

- **Email: dhhrdide@wv.gov**
- **Fax: 304-558-8736**
- **CDC Pregnancy Flu Line (to reach a CDC staff member 24/7): 404-368-2133**

Case ID:	
Medical record number:	
Contact name:	
Contact phone:	
Contact e-mail:	
Hospital name:	
Hospital zip code:	
Patient name:	
Patient DOB:	
State of residence:	

1. Patient Race (check all that apply):
☐ White
☐ Black/African-American
☐ Asian/Pacific Islander
☐ American Indian/Alaskan Native
☐ Other
☐ Unknown

2. Patient Ethnicity:
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

3. Insurance Type:
☐ Private health insurance
☐ Medicaid
☐ Self-pay
☐ Uninsured
☐ Unknown

4. Notation in medical record of "high risk" pregnancy classification?
☐ Yes ☐ No ☐ Unknown

5. Underlying medical conditions/risk factors

☐ None
☐ Asthma
☐ Other chronic lung disease
☐ Metabolic disorder (e.g. pre-existing diabetes, hyper or hypothyroidism)
☐ Gestational diabetes
☐ Obesity (prior to pregnancy)
☐ Cardiovascular disease, excluding hypertension
☐ Hypertension (prior to pregnancy)
☐ Gestational Hypertension/Preeclampsia/Eclampsia
☐ Neurological disorder including seizure disorder
☐ Tobacco use during current pregnancy
☐ Immunosuppression, specify_____
☐ Cancer diagnosed in last year
☐ Hematologic disorder (e.g. hemoglobinopathy)
☐ Hepatic disorder
☐ Substance abuse during current pregnancy (e.g. alcohol, illegal drug use)
☐ Psychiatric disorder
☐ Renal disease
☐ Other, specify:_____
☐ Unknown

6. Prenatal medications upon admission to hospital:

7. Estimated due date? __/__/__ ☐ Unknown
8. Gestational age at admission (wks): ____ ☐ Unknown

9. Date of symptom onset: __/__/__ ☐ Unknown
10. Date initial care sought: __/__/__ ☐ Unknown

11. Did mother receive rapid influenza test? ☐ Yes ☐ No ☐ Unknown
Result of rapid test? ☐ Positive ☐ Negative ☐ Unknown

12. Did mother receive rRT-PCR test? ☐ Yes ☐ No ☐ Unknown
Result of rRT-PCR test? ☐ Positive ☐ Negative ☐ Unknown

13. Did mother have any viral cultures? ☐ Yes ☐ No ☐ Unknown
Result of viral cultures? ☐ Positive ☐ Negative ☐ Unknown

14. Did mother receive DFA/IFA test? ☐ Yes ☐ No ☐ Unknown
Result of DFA/IFA cultures? ☐ Positive ☐ Negative ☐ Unknown

15. Did influenza testing confirm an influenza type or sub-type?

☐ Yes - Flu A identified / Subtype identified (list subtype)_____
☐ Yes - Flu A identified/ unknown Subtype
☐ Yes – Flu B identified–
☐ Yes – Flu C identified–
☐ No flu type known

16. Did mother receive any influenza vaccine in 2010 or 2011 more than 2 weeks before onset of illness? ☐ Yes ☐ No ☐ Unknown
If yes,2009 pandemic seasonal flu vaccine? ☐ Yes ☐ No ☐ Unknown
2009 pandemic H1N1 vaccine? ☐ Yes ☐ No ☐ Unknown
2010-2011 seasonal flu vaccine? ☐ Yes ☐ No ☐ Unknown

17. Did mother take antiviral medications after becoming ill?
☐ Yes (list below) ☐ No ☐ Unknown

□ Oseltamivir (Tamiflu®)	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Zanamivir (Relenza®)	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Rimantadine	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Amantadine	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ IV Peramivir	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Other	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Unknown antiviral	

18. Date of hospital admission: __/__/__ ☐ Unknown
19. Admitted to ICU? ☐ Yes ☐ No ☐ Unknown
20. More than one ICU admission (e.g. transfer or readmission) for this illness?
☐ Yes ☐ No ☐ Unknown
21. Date of initial ICU admission: __/__/__ ☐ Unknown
22. Total days in ICU_____
☐ Not yet discharged ☐ Unknown
23. Date of hospital discharge/death: __/__/__ ☐ Not yet discharged
24. Maternal death? ☐ Yes ☐ No ☐ Unknown

25. Other medications during hospitalization(s)
☐ None
☐ Antibiotics
☐ Antihypertensives
☐ Vasopressors
☐ Systemic corticosteroids. If yes, please specify reason (e.g. for maternal health or fetal lung maturity) _____
☐ Nebulized drugs (e.g. albuterol)
☐ Antiepileptics
☐ Antiglycemics
☐ Tocolytic agents
☐ Diuretics
☐ Narcotic Analgesic
☐ Sedative/Hypnotic
☐ Antifungal
☐ Other, specify:_____
☐ Unknown

26. Was she diagnosed with:

Pneumonia? ☐ Yes, date: __/__/__ ☐ No ☐ Unknown

If pneumonia, check all known types/results of respiratory cultures

Culture type obtained	**Bacterial** ☐ Yes ☐ No ☐ Unknown	**Viral** ☐ Yes ☐ No ☐ Unknown	**Fungal** ☐ Yes ☐ No ☐ Unknown
Any positive result?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

List organisms identified if known_____

_____

ARDS? ☐ Yes, date: __/__/__ ☐ No ☐ Unknown

27. Did she require mechanical ventilation?

☐ Yes, then how many days?___ ☐ No ☐ Unknown

Date of intubation: __/__/__

28. Date of delivery (or spontaneous/elective abortion): ___/___/___

☐ Unknown

29. Delivery location:

☐ Labor and delivery
☐ Emergency department
☐ Intensive care unit
☐ Other, specify:_____
☐ Unknown

30. Method of delivery:

☐ Undelivered
☐ Vaginal
☐ Cesarean, scheduled
☐ Cesarean, emergency
☐ Cesarean, unknown if emergency or scheduled
☐ Unknown

31. Other delivery details/complications:

32. Outcome:

☐ Live birth
☐ Stillbirth
☐ Spontaneous abortion
☐ Undelivered fetal demise
☐ Unknown

33. Multiple gestation? (e.g. twins, triplets), ☐ Yes, Number___ ☐ No ☐ Unknown

NOTE: If multiple gestation pregnancy, copy, complete, and attach pages 4 and 5 of case report form for each infant

34. Gestational age at delivery (wks): ____

35. Infant birthweight: _____ ☐ Unknown

36. Infant 1-minute Apgar? ____ ☐ Unknown
37. Infant 5-minute Apgar? ____ ☐ Unknown
38. Infant to NICU? ☐ Yes ☐ No ☐ Unknown
39. Date of NICU admission: __/__/__ ☐ Unknown
40. Date of NICU discharge: __/__/__ ☐ Not yet discharged ☐ Unknown
41. Date of infant hospital discharge/death: __/__/__ ☐ Unknown
42. Infant death? ☐ Yes ☐ No ☐ Unknown

43. Infant conditions during hospitalization
☐ None
☐ Skin rash
☐ Fever
☐ Temperature instability
☐ Bradycardia
☐ Apnea
☐ Petechiae
☐ Chorioretinitis
☐ Cataracts
☐ Seizures
☐ Meningitis
☐ Other neurologic abnormality, specify:_____
☐ Hearing loss
☐ Pneumonia
☐ Sepsis
☐ Respiratory distress, specify cause: _____
☐ Hypoglycemia
☐ Hyperbilirubinemia/Jaundice (Etiology not specified
☐ Hyperbilirubinemia/Jaundice R/T Prematurity
☐ Other, specify_____
☐ Unknown

44. Did infant receive rapid influenza test?	☐ Yes	☐ No	☐ Unknown
Result of rapid test?	☐ Positive	☐ Negative	☐ Unknown
45. Did infant receive rRT-PCR test?	☐ Yes	☐ No	☐ Unknown
Result of rRT-PCR test?	☐ Positive	☐ Negative	☐ Unknown
46. Did infant have any viral cultures?	☐ Yes	☐ No	☐ Unknown
Result of viral cultures?	☐ Positive	☐ Negative	☐ Unknown
47. Did infant receive DFA/IFA test?	☐ Yes	☐ No	☐ Unknown
Result of DFA/IFA cultures?	☐ Positive	☐ Negative	☐ Unknown

48. Infant outcome (any details regarding isolation, antivirals, or complications)**:**

49. Narrative (any relevant additional information on mother and/or infant)**:**
